

TESTIMONY OF THE NATIONAL KIDNEY FOUNDATION
KEVIN LONGINO, CEO
BEFORE THE HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HHS, EDUCATION, AND RELATED AGENCIES
IN SUPPORT OF FY 2024 FUNDING FOR CDC AND NIDDK

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I am Kevin Longino, CEO of the National Kidney Foundation (NKF). I am also a kidney transplant recipient. I appreciate the invitation to appear before the Subcommittee to highlight the significant burden that chronic kidney disease (CKD) places on patients, families and caregivers, society, and our nation's health care system.

NKF respectfully requests that the Chronic Kidney Disease Initiative at the Centers for Disease Control and Prevention (CDC) be increased to \$15 million over the next five years. We further request an increase for kidney research activities under the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) that is at least proportional to the funding increase for NIH overall. NKF appreciates the committee's past support for CKD related programs at the Centers for Disease Control and Prevention (CDC) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). These investments represent a shift in the government's strategy from one that pays for kidney disease to one that emphasizes kidney health. By investing in CKD awareness, prevention, detection, and management, we can reduce the burden of kidney disease, improve quality of life, and reduce health care spending.

Kidney disease affects 38 million adults in the U.S. and beneficiaries with a kidney disease diagnosis costs Medicare \$136 billion annually. Another 80 million adults, or 1 in 3, in the U.S. are at risk for developing CKD because they have diabetes, hypertension, a family history of chronic kidney disease, or other risk factors. Unfortunately, in primary care settings, 90% of kidney disease is undiagnosed and patients receive no nephrology care prior to their kidney failure, including as many as 40% whose kidney disease is advanced (stage 4 or stage 5). By the time most kidney disease is diagnosed—at an advanced and costly stage—treatment choices are limited to transplant or dialysis.

While dialysis replaces kidney function for more than 550,000 patients, it is not a cure for kidney failure. The five-year survival rate is only 35% - half that of the survival rate for all cancers. According to the U.S. Renal Data System, patients ages 66-74 had a four-fold higher likelihood of mortality compared to individuals with cancer or stroke and a three-fold higher mortality rate compared to individuals with heart failure or a heart attack.

In addition to kidney failure, CKD contributes to and accelerates several other conditions, notably cardiovascular disease (CVD). The risk of heart failure, atrial fibrillation, stroke, and coronary heart disease is approximately double in patients with CKD, resulting in a mortality rate for Medicare beneficiaries with CKD that is twice that of beneficiaries without CKD.

Patient quality of life is also significantly affected by kidney disease. Individuals with kidney failure often experience cognitive challenges, depression, infection, dietary restrictions, anemia, fatigue, bone loss, and other factors and the hospitalization rate for Medicare kidney patients is 2.4 times higher than for Medicare beneficiaries without CKD.

The cost of kidney disease and kidney failure is astronomical. Medicare spends an estimated \$136 billion annually, nearly 25% of Medicare expenditures, on the care of people with a kidney disease diagnosis. Individuals with kidney *failure* represent 1% of Medicare beneficiaries but comprise 6% of Medicare fee-for-service expenditures. *The need for an increased federal commitment to address the societal and economic burdens of CKD is undeniable.*

CKD is also characterized by stark racial, ethnic, and socioeconomic inequalities. People of African American, Hispanic, American Indian or Alaska Native, Asian American, or Native Hawaiian or Pacific Islander descent are all at increased risk for developing the disease. For example, Blacks/African American people comprise 13% of the U.S. population but represent 35% of those with kidney failure, treated with dialysis, or kidney transplantation. Blacks/African Americans and Hispanic/Latinos have less access to the kidney wait list, experience a longer wait once listed, and are less likely to receive a transplant from a living donor or a deceased donor compared to White patients with kidney failure. White patients are 3 times more likely to receive a living donor kidney compared to Black patients and 1.7 times greater than that of Hispanics. In 2020, Blacks comprised 12% of living donor recipients while Whites comprised 64%.

Alarming as some of these statistics may be, there is significant hope for individuals facing a CKD diagnosis. Simple interventions can improve kidney and CVD outcomes, like medical nutrition therapy, blood pressure control, diabetes control, and common, affordable drugs such as statin-based therapies. Further, a new class of drugs, sodium-glucose co-transporter-2 (SGLT-2) inhibitors and non-steroidal Mineralocorticoid Receptor Antagonists (nsMRAs) show extraordinary efficacy at attenuating risk of dialysis and CVD, particularly heart failure in

patients with diabetes and CKD, as well as in patients with CKD without diabetes. Observational studies have shown multidisciplinary care that may include a dietitian, pharmacist and nephrologist is also associated with improved outcomes for the T2D with CKD population.

Implementing targeted therapies can significantly improve patient outcomes by slowing the progression of CKD to kidney failure and reducing risk for CVD, and death, especially for at-risk communities. Successful CKD management, however, hinges on patient access to timely awareness, diagnosis, and management.

The CDC Chronic Kidney Disease Initiative plays a critical role in assuring timely diagnosis and management of CKD. As a result of an FY 2022 increase in funding, NKF and the National Association of Chronic Disease Directors partnered on the *CKD Intercept*, an initiative to increase public awareness, educate clinical professionals, and expand health system capacity to diagnose and manage CKD in primary care settings. Implemented in partnership with local health systems, federally qualified health centers, public health departments, community organizations, and other stakeholders the program is tailored to the community's needs. While the initiative is still in its early stages, it is already demonstrating strong results, with participating partners experiencing a 28 percent increase in CDK testing.

NKF hopes to replicate and accelerate deployment of this model with partners across the country. Preserving the current funding level would allow these activities to continue in two to five states. Growing the program to serve all fifty states would require a sustained investment of approximately \$15 million.

With regard to biomedical research, in 2021, NKF released a Research Roadmap that highlighted where additional funding could bridge existing deficits in CKD detection and management, reduce incidence and disparities, improve outcomes, and lower healthcare costs. Our roadmap was the culmination of input from nephrology leaders and from kidney patients, family members and caregivers, and living kidney donors.

Despite CKD's impact on patients and Medicare, NIH funding for kidney disease research is only about \$700 million annually. FY 2021 funding for NIDDK increased by less than 1% and the FY 2022 increase was 3.4%. From FY 2017-2021, NIH monetary support for kidney research increased at half the rate of NIH funding overall. As a result, innovation in kidney research and treatment has lagged that of other diseases. We appreciate the 4.4% increase for NIDDK in FY 2023 and request continued increases in funding to accelerate new therapies that have the potential to provide cost savings to Medicare. We request a percentage increase for kidney research proportional to or greater than that of NIH overall.

NKF is very appreciative of the Committee's direction to NIDDK in FY2023 to prioritize research into the adoption of new equations for estimating the Glomerular Filtration Rate that do not include race as a modifier. We also recognize the Committee's encouragement for NIDDK to provide additional investments in CKD clinical trials, including diversity of participants, and to support the delivery of evidence-based care in under-represented populations.

Thank you again for the opportunity to testify and for your consideration of these important kidney disease activities in Fiscal Year 2024.